INSTRUCTION FOR COMPLETING
THE APPLICATION FOR NON-RESIDENT PHARMACY REGISTRATION

Please read carefully and follow all instructions. Incomplete applications delay the registration process.

The application must be typed or legibly printed.

All questions must be answered. If the question does not apply, write N/A. If the answer is not known, write unknown.

If ownership is a partnership, corporation, or other, the additional information must be attached. Refer to the application for the documentation required.

The address of the pharmacy must be the physical location, not post office boxes.

The board office must be in receipt of a completed application and the fee before the application will be processed.

Enclose a copy of your DEA certificate if you are registered to dispense controlled substances.

Enclose a license verification from your home-state stating that your pharmacy is actively licensed and in good standing with that Board and a copy of your home state pharmacy registration.

Signatures are required for the owner and the pharmacist-in-charge. **If the owner and PIC are the same individual, both portions must be signed and notarized.**

Application must be accompanied with a check or money order in the amount of $112.00.

All registrations will expire on June 30 of each year and such registration will be canceled if not renewed annually by July 31st. The $112.00 fee is not prorated.

The application and fee, along with any supporting documents should be sent to the address at the top of the application.

CHECKLIST:
_____ (1) Application completed, including two (2) signatures and notaries?
_____ (2) Copy of corporate officers or other documentation enclosed?
_____ (3) Check or money order in the amount of $112.00 enclosed?
_____ (4) Copy of DEA certificate enclosed?
_____ (5) License Verification from Home State enclosed?
_____ (6) Copy of Home State Pharmacy Registration enclosed?
_____ (7) Copy of most recent Home State inspection report enclosed?

NON-RESIDENT PHARMACY REGISTRATIONS

The following circumstances require applying for a new non-resident pharmacy permit.

NEW PHARMACY: A pharmacy registration is required prior to doing business as a pharmacy in the State of Kansas.

CHANGE OF ADDRESS: A non-resident pharmacy currently registered with the Board of Pharmacy may not continue to ship into the state from their new address without prior approval from the Board. This approval is obtained through the issuance of a new non-resident pharmacy registration. It is recommended that an application be made for the new location approximately one month in advance.

CHANGE OF OWNER: A new non-resident pharmacy registration is required when there is a 50% or more change in controlling interest. An application must be made to the Board office by the new ownership. It is recommended that an application be made approximately one month in advance of the ownership change. Within 5 days of the change date, the previous registration should be returned to the Board office. If the ownership change is less then 50%, notification must be made to the Board office in writing of the change of ownership, but does not require a new registration.

CHANGE IN PHARMACIST-IN-CHARGE: A two week written resignation notice is required to be given to the owner and a copy sent the Board office. A new application changing the PIC needs to be initiated with the Board office so the new PIC can effectively be in place within 30 days of the resignation of the former PIC.

FOR OFFICE USE ONLY

REG NUMBER: _____

DATE: _____

Check#_____$__

KANSAS STATE BOARD OF PHARMACY
800 SW JACKSON, ROOM 1414
TOPEKA, KS 66612
(785) 296-4056
FAX (785) 296-8420

FEE $112.00

APPLICATION FOR NON-RESIDENT PHARMACY REGISTRATION

This application is being made for the following reason: (check all that apply):

_____New Pharmacy _____Change of Address _____Change of Ownership _____Change of PIC

If a Change of Address or Ownership: Previous License Number (if applicable)_____

Or Previous Address_____

The owner hereby makes application as follows:

_____
BUSINESS NAME OF OWNER

_____
ADDRESS OF OWNER

_____
CITY STATE ZIP PHONE NUMBER

_____
E-MAIL ADDRESS

Type of ownership: ____Individual ____Partnership ____Corporation _____Other

IF PARTNERSHIP, attach additional listing of names and percentage of ownership.
IF CORPORATION, attach additional officer and owners of stock.
IF OTHER, attach additional sheet indicating the type of ownership.

Type of Pharmacy: _____Renal Dialysis _____Retail Chain _____Retail Community

_____Hospital/Institution ____Ambulatory Surgery Center _____ Other _____

The owner makes application to establish and maintain a pharmacy under the name of and at the location as follows:

_____
NAME OF PHARMACY

_____
PHYSICAL ADDRESS OF PHARMACY

_____
CITY STATE ZIP **TOLL FREE** TELEPHONE NO.

_____
E-MAIL ADDRESS WEB SITE ADDRESS

Does your pharmacy have a web site? ____Yes ____No
If so are patients able to purchase prescriptions on it? ____Yes _____No

DESIGNATED RESIDENT AGENT: _____
NAME ADDRESS PHONE

Designated resident agent defaults to the Secretary of State. To use the default – check here _____

Hours pharmacy is open _____ to _____

Hours store / facility is open _____to _____

Total hours per week a pharmacist will be held on duty in facility_____

The above named owner places the following licensed pharmacist as pharmacist-in-charge of the pharmacy indicated above:

_____
NAME OF PHARMACIST IN CHARGE LICENSE NUMBER

PHARMACIST IN CHARGE EMAIL

ATTACH A LIST OF OTHER LICENSED PHARMACISTS EMPLOYED IN SAID PHARMACY.

Is this pharmacy registered by the DEA to dispense controlled substances? _____
If Yes, please enclose a copy of the DEA certificate.
If No, has application been made to DEA? _____ Date applied: _____

Is the pharmacy currently licensed in the state of residence ____Yes ____No

Effective Date of Business / Pharmacy: _____

In which other state(s) are you Licensed?_____

Drug Schedules **(Check all that apply)**

___ Schedule I ___ Schedule II/nonnarcotic ___ Schedule II/narcotic

___Schedule III/nonnarcotic ___ Schedule III/narcotic ___ Schedule IV ___ Schedule V

Please attach a copy of the most recent inspection report conducted by the state's licensing agency.

1. Has the owner or the responsible pharmacist ever had its registration under State or Federal law revoked, suspended, or placed in a probationary status, or otherwise disciplined? ____Yes ____No
2. Has the owner or the responsible pharmacist ever been convicted under state or federal law of a felony or misdemeanor violation involving drugs? _____Yes ____No
3. Has the applicant been convicted of any violation of State or Federal law relating to controlled substances? ___Yes ____No
4. If answer (3) was "Yes,'' was the conviction a felony? ____Yes ____No
5. Has any previous registration held by the applicant under any name or corporate or legal entity under the Controlled Substances Act or Kansas Uniform Controlled Substance Act been surrendered? _____Yes _____No

If YES was answered to any of the above questions, an additional attachment must accompany this application explaining the circumstances in detail.

The owner and/or responsible pharmacist understand the registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed annually by the 31st day of July.

OWNER/CORPORATE OFFICER PORTION

I, _____, being the owner or agent of the owner of the pharmacy indicated on the reverse of this application, do solemnly swear (or affirm) that, if a registration be issued as requested, such pharmacy will be conducted and operated in full compliance with the Pharmacy Act and the Controlled Substance Act of the State of Kansas and all other laws of Kansas so long as continued under such registration and that the registration will expire ANNUALLY on JUNE 30TH and such registration will be canceled if not renewed ANNUALLY by July 31ST.

I further solemnly swear (or affirm) that the statements and representations made in the foregoing application are true and correct.

_____
SIGNATURE OF OWNER OR AGENT OF OWNER

Signed and sworn to (or affirmed) before me on _____day of _____, 20____.

(Seal)

My commission expires _____ _____
SIGNATURE OF NOTARY PUBLIC

PHARMACIST-IN-CHARGE PORTION

I, _____, being the pharmacist-in-charge of the pharmacy indicated on this application, do solemnly swear (or affirm) that I understand that if such registration is issued, it will be issued jointly to the owner and myself and, in the event that I shall no longer be pharmacist-in-charge of such pharmacy, I shall notify the Executive Secretary of the Board of Pharmacy of Kansas and forward such registration to the Executive Secretary.

I further swear (or affirm) that I understand all my responsibilities to the Board of Pharmacy of Kansas as pharmacist-in-charge of such pharmacy and that I will comply with the Pharmacy Act and the Controlled Substances Act of the State of Kansas and all other laws of Kansas and that the registration will expire ANNUALLY on JUNE 30TH and such registration will be canceled if not renewed ANNUALLY by JULY 31ST.

_____
SIGNATURE OF PHARMACIST IN CHARGE

Signed and sworn to (or affirmed) before me on _____day of _____, 20_____.

(Seal)

My commission expires _____ _____
SIGNATURE OF NOTARY PUBLIC

NOTE: Signatures are required for the owner and the pharmacist-in-charge. If the owner and PIC are the same individual, both portions must be signed and notarized.